

Department of Veterans Affairs (VA)
Federal Advisory Committee
National Academic Affiliations Council (NAAC)
Meeting Minutes January 10-11, 2013
Office of Academic Affiliations Suite 870
1800 G Street
Washington, DC

The National Academic Affiliations Council met on January 10-11, 2013, at the Office of Academic Affiliations in Washington, DC. A quorum was present, affording the Committee the opportunity to conduct normal business.

Council members present: Jordan J. Cohen, MD, (Chair) President Emeritus, Association of American Medical Colleges; Norman B. Anderson, PhD, Chief Executive Officer, American Psychological Association; Geraldine D. Bednash, PhD, RN, FAAN, Chief Executive Officer and Executive Director, American Association of Colleges of Nursing; Malcolm Cox, MD (Ex-Officio), Chief Academic Affiliations Officer, U.S. Department of Veterans Affairs; David W. Gorman, Retired Executive Director, Disabled American Veterans National Service and Legislative Headquarters; David M. Irby, PhD, Professor of Medicine and former Vice Dean for Education, University of California San Francisco School of Medicine; Darrell G. Kirch, MD, President and Chief Executive Officer, Association of American Medical Colleges; Risa Lavizzo-Mourey, MD, President and Chief Executive Officer, Robert Wood Johnson Foundation; Kathleen A. Long, PhD, RN, FAAN, Dean, School of Nursing and Associate Provost, University of Florida; Michael F. Mayo-Smith, MD, MPH, (Ex-Officio), Director, New England Healthcare Network (VISN 1), U.S. Department of Veterans Affairs; J. Lloyd Michener, MD, Chair, Department of Community and Family Medicine, Duke University School of Medicine; Claire Pomeroy, MD, MBA, Vice Chancellor for Human Health Sciences and Dean, University of California Davis School of Medicine; Wayne J. Riley, MD, MPH, MBA, MACP, President and Chief Executive Officer, Meharry Medical College.

Council members unable to attend: Stephen C. Shannon, DO, MPH, President, American Association of Colleges of Osteopathic Medicine.

VA staff presenting at the meeting: Holly H. Birdsall, MD, PhD, Deputy Chief, Office of Research and Development, VHA; Barbara K. Chang, MD, MA, FACP, Director, Medical & Dental Education, VA Office of Academic Affiliations, VHA; Robert L. Jesse, MD, PhD, Principal Deputy Under Secretary for Health, VHA; Joel Kupersmith, MD, Chief, Office of Research and Development, VHA; William J. Marks, Jr., MD, Chief, Health Professions Education, VA Office of Academic Affiliations, VHA; Karen M. Sanders, MD, Deputy Chief, VA Office of Academic Affiliations, VHA; Antonette M. Zeiss, PhD, Chief Consultant, Office of Mental Health Services, (Retired), VHA; Robert A. Zeiss, PhD, Director, Associated Health Education, VA Office of Academic Affiliations, VHA.

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Guest presenters: Susan M. Adams, PhD, APRN, PMHNP, CNS-BC, FAANP, Director PMHNP Program, Vanderbilt University and Board Member, American Psychiatric Nurses Association; Cynthia D. Belar, PhD, Education Directorate, American Psychological Association; Deborah J. Hales, MD, Director, Division of Education, American Psychiatric Association; Jane M. Kirschling, PhD, RN, FAAN, President, American Association of Colleges of Nursing; Jack Krakower, PhD, Senior Director, Medical School Financial and Administrative Affairs, Association of American Medical Colleges; John E. Prescott, MD, Chief Academic Officer, Association of American Medical Colleges; Andrew S. Pomerantz, MD, National Mental Health Director for Integrated Care, VHA; Mary Schohn, PhD, Director, Mental Health Operations, VHA.

Other VHA staff attending: Louise Arnheim, MPA, Strategic Communications Manager, Office of Research and Development, VHA; David Atkins, MD, MPH, Associate Director, Health Service Research and Development Service, Office of Research and Development, VHA; F. Alex Chiu, PhD, Senior Program Manager, Office of Research and Development, VHA; Mary Dougherty, DNSc, Director, VA Nursing Academy, Office of Academic Affiliations, VHA; Stuart Gilman, MD, MPH, Director, VA Advanced Fellowships and Professional Development & Director, Centers of Excellence in Primary Care Education, Office of Academic Affiliations, VHA; Debbie Hettler, OD, MPH, FAAO, Clinical Director, Associated Health Education, Office of Academic Affiliations, VHA; Gloria Holland, PhD, MBA, Special Assistant for Policy & Planning, VA Office of Academic Affiliations, VHA; Marsden H. McGuire, MD, Deputy Chief Consultant for Mental Health Standards of Care, VACO Mental Health Services, VHA; Joanne Pelekakis, MLS, Health Systems Analyst, Office of Academic Affiliations, VHA.

Members of the public attending: Margaret Hardy, JD, Director Graduate Medical Education Policy and Analysis, American Osteopathic Association; Deana M. McRae, Associate Director, Government Relations, American Psychiatric Association; Judith Mun, Policy and Public Affairs Specialist, American Association of Colleges of Osteopathic Medicine; Pamela Murphy, MSW, Director of Government Relations, Association of American Colleges of Osteopathic Medicine.

MINUTES

Thursday January 10, 2013

Welcome and Introductions

Jordan J. Cohen, MD, Chair NAAC

Dr. Cohen welcomed the members and guests to the third meeting of the National Academic Affiliations Council (NAAC). Members introduced themselves followed by self-introductions of VHA staff and guests in attendance.

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**Review of February 8-9, 2012 and June 5-6, 2012 Meetings and Council
Recommendations**

OAA staff reviewed the NAAC's recommendations from the first two meetings and reported on the actions taken by VA to address these recommendations.

NAAC February 8-9, 2012 Recommendations:

Dr. Karen M. Sanders, Deputy Chief, Office of Academic Affiliations, reviewed the status of the Recommendations from the NAAC's first meeting on February 8-9, 2012. These recommendations and their associated Action Plan have been approved by VA leadership, and significant progress has been made on addressing the recommendations.

Recommendation 1: VA and the academic community should examine the feasibility and potential mutual advantages of entering into novel partnerships – such as new sharing agreements, strategic alliances and joint ventures – in order to strengthen their joint commitment to delivering high quality, evidence-based, and efficient care to individuals and populations. Recognizing the complexity of developing relationships beyond traditional academic affiliations, the NAAC further recommends that a NAAC subcommittee be chartered to explore this issue in more detail.

VA Response: Concur. VA will explore the feasibility of joint ventures with academic affiliates by initiating a time-limited subcommittee under the authority of the NAAC to explore authorities and opportunities for joint ventures and report back to the NAAC.

Progress: A Joint Venture Task Force of NAAC members was formed in the summer of 2012, chaired by Dr. Lloyd Michener. The Task Force has held multiple conference calls to develop recommendations for the creation of a formal NAAC Subcommittee. The Task Force will present its report later in this meeting.

Recommendation 2: VA should continue to support modes of clinical education that foster the clinical skills, professional attitudes and systems awareness needed for patient-centered care and continue to promote the adoption of such educational modes by its academic affiliates. VA should:

- (a) Emphasize longitudinal learning experiences in order to promote sustained, supportive and trustworthy relationships among team members and between teams and their patients;
- (b) Expand interprofessional learning experiences that emphasize effective communication, shared decision making, and systems-based practice and improvement in order to promote high-functioning team-based practice;

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- (c) Continue to support the demonstration projects currently underway that examine the effectiveness of innovative models of health professions education (i.e., the Centers of Excellence in Primary Care and Specialty Care Education) and develop additional demonstration projects to expand the evidence base needed for rational redesign of learner experiences;
- (d) Explore options for re-balancing VA's educational portfolio and resources around models of learning that promote the development of proficiency in the clinical and system skills needed for patient-centered and interprofessional, team-based care.

VA Response: Concur. VA will continue to support innovative models of clinical education through the advice and consultation of an OAA Strategic Planning Advisory Committee for Health Professions Education. The Committee will explore innovative educational methods and recommend strategic directions for the VA educational portfolio. The Committee will be advisory to the Chief Academic Affiliations Officer and have broad field, program office, and VHACO leadership representation.

Progress: A Subcommittee of the National Leadership Council's Workforce Development Committee was established in fall 2012. The Health Professions Education Strategic Planning Committee (HPESP), is co-chaired by Susan Bowers, VISN Director VISN 18 and Dr. William Marks, Chief, Health Professions Education, VA Office of Academic Affiliations. The first meeting was held the week of January 7th, with a face to face meeting planned for March. The NAAC will be kept informed of discussions and recommendations.

Recommendation 3: VA should continue to enhance nursing school partnerships, initiated under the VA Nursing Academy pilot program, by expanding this foundational academic partnership program.

VA Response: Concur.

Progress: VHA approved a 1-year extension of the VA Nursing Academy (VANA) at 12 presently active sites. Thereafter, sites are expected to continue their partnerships with resources jointly provided by the local VA facility and School of Nursing. More recently, an expansion of VANA entitled VA Nursing Academic Partnership (VANAP) was approved by the Under Secretary for Health. A Request for Proposals (RFP) for 6 additional sites will be distributed in January 2013.

Recommendation 4: VA should re-examine the structure and function of medical center Academic Partnership Councils to ensure they are broadly representative of all local academic affiliates and provide effective oversight of all programs jointly administered by VA and its academic partners. VA should consider policy changes,

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if necessary, and should mount demonstration projects to examine the effectiveness of new models of local affiliation governance.

VA Response: Concur. See recommendation #5. Recommendations 4 and 5 will be overseen by the same subcommittee.

Recommendation 5: VA should re-examine the roles of medical center and VISN leadership in the oversight and management of its statutory educational mission. VA should consider:

- (a) Strengthening the role and function of the DEO;
- (b) Better defining the resources necessary for the DEO to manage health professions training and academic affiliations effectively;
- (c) Clarifying the roles of the medical center Chief of Staff, Chief Nursing Executive, and VISN Academic Affiliations Officer in the oversight and management of health professions training and academic affiliations;
- (d) Developing performance metrics for medical center and VISN leaders with responsibilities for health professions training and academic affiliations; and
- (e) Designing professional development programs for medical center and VISN leaders with responsibilities for health professions training and academic affiliations.

VA Response: Concur. VHA will develop policy and implementation procedures for academic affiliations oversight by establishing a new National Leadership Council subcommittee. The subcommittee will report to the Healthcare Delivery Committee and be co-chaired by senior OAA and field executives. The Chief Academic Affiliations Officer (10A2D) and ADUSHOM for Clinical Operations (10NC) will have joint responsibility for implementing approved recommendations.

Progress: The Field Academic Affiliation Management Subcommittee (FAAMS) of the Healthcare Delivery Committee was formed in October 2012. It is co-chaired by Elizabeth (Lisa) Freeman, Director, Palo Alto, VA Medical Center and Dr. Barbara K. Chang, Director, Medical & Dental Education, VA Office of Academic Affiliations. The Subcommittee has met twice and is focusing on academic issues at the medical center level. The NAAC will be kept informed of discussions and recommendations.

NAAC June 5-6, 2012 Recommendations:

Dr. William J. Marks, Chief, Health Professions Education, Office of Academic Affiliations, presented the status of the recommendations from the NAAC's June 5-6, 2012 meeting. These recommendations and the VHA Action Plan for addressing them have not been formally approved; however, Dr. Marks presented a general overview of the proposed actions.

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Recommendation 1: The NAAC applauds the quality of VA mental healthcare and endorses VA's recent efforts to further enhance access to care by increasing the recruitment of mental health practitioners. In order to increase the future supply of mental health professionals, the NAAC recommends that VA and its academic affiliates expand the mental health professions training pipeline. The NAAC further recommends that this be built around innovations in mental healthcare delivery, especially interprofessional team-based care, rather than relying solely on existing models of care.

VA Expected Action: Concur.

Progress: OAA issued an RFP in September 2012 to expand mental health professions trainee positions. An enthusiastic field response resulted in funding for 202 additional positions at 43 facilities for Academic Year (AY) 2013-2014. These positions will augment existing training programs with an interprofessional focus. Additional expansion is planned for AY 2014-2015, as well as an RFP for expansion of VA's Substance Abuse Fellowship. OAA is also working with VHA's Workforce and Consulting Office to ensure that trainees are aware of employment prospects within VHA.

Recommendation 2: The NAAC appreciates that healthcare trainees require background screening to ensure public trust. VA presently requires a Special Agreement Check (SAC), which includes fingerprints, as the minimum screening procedure to gain access to VA facilities and IT systems, but higher-level screening is under active consideration. The NAAC recommends that a thorough reexamination of VA's trainee security policies and procedures be conducted to ensure that:

- a. Modifications to present security policies and procedures do not have untoward consequences. For example, the inability of some VA facilities to badge or fingerprint trainees in a timely manner affects trainee assignment and has the potential to negatively affect patient care, clinical education and affiliation relationships.
- b. The level of background screening established for clinical trainees is determined not only by business requirements but also by the relative risk posed by this population. For example, VA might find that a SAC-only screening process is sufficient, in part because of the young age, prior background screenings, and transient nature of the clinical trainee population.

VA Action: Pending.

Recommendation 3: The NAAC recognizes that VA's academic affiliates utilize a wide variety of background checks, up to and including fingerprint checks, but that these

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vary widely by profession and between schools. With this in mind, the NAAC recommends that VA and its academic affiliates:

- c. Explore options for ensuring that all clinical professions and academic affiliates utilize the highest level of commercial background screening available (including fingerprint checks); and
- d. Examine the feasibility of developing a system of reciprocity in background screening that would meet the expectations and requirements of all stakeholders.

VA Action: Pending.

Recommendation 4: Existing research collaborations between VA and its academic affiliates may provide examples of sharing, strategic alliance, and joint venture agreements. With this in mind, the NAAC recommends that VA compile a list of such sites for use in the NAAC's ongoing analysis of different forms of partnerships between VA and the academic community.

VA Expected Action: Concur.

Progress: The Office of Research and Development is currently developing a catalog of research collaborations.

Council Discussion:

NAAC members engaged in a discussion of their previous recommendations and progress to date. The formation of two new VHA National Leadership Council Committee Subcommittees was of particular interest to the NAAC. The opportunity for a bidirectional conduit between VHA field leaders and national policy makers was viewed as an important step in enhancing VA's statutory educational mission at the national level. Members expressed interest in receiving further updates about the actions of the Subcommittees and the progress made in addressing strategic and operational issues for education.

The Council complimented VA's expansion of mental health education, and expressed interest in VA's future plans. Members emphasized the importance of communication with colleges and universities and the provision of appropriate lead times to allow for collaborative planning at both national and local levels.

The Council was pleased with VA's continuing efforts to further strengthen the partnerships between VA and Schools of Nursing. Members expressed support for the enterprise-wide expansion of the program.

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The Council expressed concern about the lack of formal action on the recommendations of the June 5-6, 2012 meeting and the lack of education and research leadership representation on VA's HSPD-12 Steering Committee.

Report from the NAAC Joint Venture Task Force

Dr. Lloyd Michener presented the report of the Joint Venture Task Force. Task Force members included: David W. Gorman, Retired Executive Director, Disabled American Veterans National Service and Legislative Headquarters; Kathleen A. Long, PhD, RN, FAAN, Dean, School of Nursing and Associate Provost, University of Florida; Michael F. Mayo-Smith, MD, MPH, (Ex-Officio), Director, New England Healthcare Network (VISN 1), U.S. Department of Veterans Affairs; J. Lloyd Michener, MD, Chair, Department of Community and Family Medicine, Duke University School of Medicine; and Stephen C. Shannon, DO, MPH, President, American Association of Colleges of Osteopathic Medicine. Malcolm Cox, MD (Ex-Officio), Chief Academic Affiliations Officer, U.S. Department of Veterans Affairs; and Gloria Holland, PhD, MBA, Special Assistant for Policy & Planning, VA Office of Academic Affiliations, served as staff to the Task Force.

The Task Force met multiple times over the summer and developed a set of principles to use in developing and evaluating potential joint ventures. Dr. Michener reviewed existing VA policy covering joint ventures, VA Handbook 0311 (11/8/2007). VA joint ventures must benefit VA and Veterans. They can include a broad range of external groups, are usually multi-year in nature, and can vary widely in the degree of integration between partners. VA policy specifically allows joint ventures in research and education. And although the policy sets a \$10M financial threshold for joint ventures, exceptions are provided for those primarily focused on education or research.

Dr. Michener then outlined areas of consideration and potential opportunities and barriers. Joint ventures can start small and be scaled up and can focus on anything from clinical care, education, or research to information technology and business operations. Current examples of include joint ventures between the VA and DoD, which illustrate some of the complexities of integration. There are emerging opportunities for VA joint ventures with the private sector through alignment with Accountable Care Organizations created by provisions of the Affordable Care Act. New opportunities for joint ventures might include outreach to rural or women Veterans, more effective support of family members, and quality improvement and cost efficiencies from sharing clinical, educational or research operations. Determining the most compelling areas in which to move forward will be the major task of the new Subcommittee.

To provide the NAAC with a better sense of the possibilities, the Task Force presented three scenarios of possible collaboration: healthcare delivery; population-based data sharing; and educational consortia.

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Healthcare Delivery: Selected Options for Joint Ventures

Dr. Mayo-Smith presented three scenarios for healthcare joint ventures.

Joint Outpatient Center: A joint outpatient center could function as a “Super Community Based Outpatient Clinic”. It might encompass 100,000 – 125,000 square feet, but would have no inpatient beds. A joint venture of this type between VA and an academic medical center would best be located in a geographic area with a Veteran population insufficient to support an independent outpatient clinic. A joint clinic could be staffed by practitioners with appointments and clinical privileges at both VA and the partnering facility. Under the right circumstances, clinical trainees could be included as well. Existing expertise would be broadened and services delivered in common could reduce overhead costs. A joint outpatient clinic might also offer the possibility for Veterans and their family members to receive healthcare in the same location.

Shared Inpatient Program: Neither VA nor its academic affiliates can afford to have complex inpatient facilities in all catchment areas. In addition, some smaller VA hospitals are in danger of falling below the critical mass necessary to maintain some or all inpatient services and maintain qualified specialists and subspecialists. If alternate acute care options were available, existing VA facilities could be used to address primary, rehabilitation, long term, and palliative care needs.

A shared inpatient program is the model adopted in most of the current VA-DoD joint ventures where either a VA medical center or a DoD medical treatment facility admit and treat the other’s patients. Sometimes there is a separate “VA wing” or a “DoD service”. In other examples patients are intermixed. The shared inpatient model benefits Veterans and non-Veterans alike by increasing access to a broader range of care closer to home.

Clinical Trials: Access to clinical trials should be more widely dispersed, and greater access would be especially welcomed in rural areas. A fruitful area for VA – affiliate joint ventures may lie in joint clinical trials or reciprocity in accepting patients into each other’s research protocols.

Council Discussion:

The Council discussed the growing needs for VA health care services in geographic areas distant from existing VA medical centers and the economies of scale that could accrue to both VA and its academic partners through joint ventures. In addition to expanding primary care, both could benefit from shared specialists, who are increasingly in short supply as well. Several members also emphasized that partnerships of this type will be needed to address many of the goals of the Affordable Care Act.

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The importance of including health professions education in clinically-focused joint ventures was highlighted by the Council, as was the importance of national in addition to local planning efforts. Committed leadership on both sides will be needed to drive coordinated planning that will meet both VA's national needs and the needs of its partners. Members advised the new Subcommittee to undertake "blue sky" planning, starting with the desirable and then moving to the feasible. Pilot projects will be needed to sort through the many complexities of joint ventures, determine potential return on investment, and ensure value added for both partners. There was general agreement that it will be necessary to make sure that what we think should work does indeed work better for Veterans.

Dr. Kirsch, the current chair of the Under Secretary's Special Medical Advisory Group (SMAG) noted that SMAG is hoping to facilitate collaboration between VA and HRSA to pursue joint initiatives and that the work of the NAAC's Joint Venture Subcommittee will be of interest to SMAG as well. Dr. Kirsch will coordinate the sharing of NAAC presentations/discussions at future SMAG meetings.

Population-based Data Sharing: North Carolina Example

Dr. Lloyd Michener presented a case study on the use of shared data bases from the state of North Carolina. He reviewed the evolution of primary care from the individual patient doctor relationship, to the medical home and team-based care, and now in North Carolina to the integration of primary care and public health. He defined the degrees of integration as moving through the stages of isolation, mutual awareness, cooperation, collaboration, partnership and merger.

Dr. Michener then described an example of integration in Durham, North Carolina where the Durham County Health Department and Duke Medicine have partnered to improve the health of the local community through the use of shared data. North Carolina has mapped prevalence of obesity, high blood pressure, and diabetes in relation to neighborhoods, churches, bars, grocery stores, areas of violence, places to exercise, and local community service organizations. This has allowed the state to identify underserved areas and plan for future services. Targeted Durham neighborhoods have experienced reduced hospital admissions and improvements in overall health status. VA has not been a part of this effort, and data about Veterans' health and healthcare services are an important missing piece of the initiative. VA participation would be an excellent opportunity to join an ongoing joint venture between state public health authorities and an academic medical center.

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Council Discussion:

The Council expressed strong support for these types of community-based healthcare initiatives. and encourages VA to look for ways to engage with states and local public health departments in sharing data with the goal of enhancing Veteran care and community health. Dr. Michener expressed his willingness to facilitate discussions between VA and the present joint venture partners in North Carolina. Collaborations anticipated with implementation of the Affordable Care Act may bring additional opportunities for these kinds of partnerships.

Educational Consortia: VA Examples

Barbara K. Chang, MD, MA, FACP, Director, Medical & Dental Education, VA Office of Academic Affiliations, VHA and Robert A. Zeiss, PhD, Director, Associated Health Education, VA Office of Academic Affiliations, VHA presented examples of educational consortia in VA.

Educational consortia have existed both in physician education and in associated health education for several decades. They emerged in graduate medical education in places where the school of medicine did not own a teaching hospital, and the associated physician residency programs were managed by a consortium arrangement between participating community hospitals.

VA has had longstanding participation in GME consortia in Buffalo and Milwaukee. VA policy presently bars full membership but permits disbursement agreements with consortia in the same manner as with hospital sponsors of GME. Multi-partner joint ventures would provide a vehicle for VA's full participation in these kinds of educational partnerships.

VA has had legal challenges deploying disbursement agreements with programs in professions other than medicine and dentistry, although these challenges may be resolved soon. Doing so will help address accreditation issues in programs such as podiatry and psychology arising from VA's inability to provide educational experiences in areas such as care for children and adolescents.

Council Discussion:

The Joint Venture Task Force recommended that the NAAC establish a formal subcommittee composed of existing NAAC members and other VA and non-VA experts to continue this work. The VA Office of General Counsel has determined that the NAAC has the authority to appoint subcommittees provided that their work is overseen by the parent committee and that recommendations are approved by the NAAC prior to submission to VA for consideration.

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Following discussion, the NAAC approved the recommendation of the Joint Venture Task Force to establish a Joint Venture Subcommittee. Membership will include NAAC members, VA consultants and non-VA members. Finalization of the subcommittee's charter and membership was delegated to the NAAC Chair. The Joint Venture Task Force provided Dr. Cohen with a draft charter and suggested membership. The first meeting of the Subcommittee is anticipated in Spring/Summer 2013.

Lunch Discussion

VHA Update: Robert L. Jesse, MD, PhD

Dr. Robert L. Jesse, MD, PhD, Principal Deputy Under Secretary for Health, VHA, joined the NAAC for a working lunch. Topics of discussion included the dissemination of innovation and how to share best practices. Dr. Jesse noted that VA has made great progress in implementing bar-code medication administration, yet there is no national process for sharing this expertise with other healthcare systems.

Dr. Jesse also expressed interest in why more eligible Veterans aren't using the VA system. How can VA get its message out more effectively? As the Affordable Care Act is implemented, Veteran participation in VA healthcare will be defined more by seamless access and convenience than by more traditional economic and demographic factors. What does VA need to do to "win" in the new healthcare marketplace?

NAAC members asked about VA progress in team-based care and training. Dr. Jesse responded that VA was well along with team training and is committed to team-based healthcare delivery. The Council was interested in the impact of federal government travel restrictions on team training and noted that these will have a wide impact on training and academic relationships in general.

Dr. Jesse also noted that another area of progress is in VA's widespread implementation of clinical simulation as a training tool. The immediate goal is to deploy standardized simulation equipment across the system and then develop innovative curricula in a number of areas. Council members reflected that the opportunity exists to do this in collaboration with the academic community.

National and VA Models of Mental Healthcare Delivery

Antonette M. Zeiss, PhD, Chief Consultant, Retired, Mental Health Services, VHA, presented an overview of national and VA models of mental health healthcare delivery.

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VA's goal is to provide holistic, interprofessional care for physical and mental health problems, with mental health care as an essential component of overall health care. The integration of mental health in VA primary care is a key example and VA's mental health records are fully integrated into the overall electronic health record. VA aims to serve all eligible Veterans with accessible, evidence-based mental health services when and where they need them. VA intervenes with returning Veterans early in the course of mental health problems, with the goal of being there for the *lifetime* of all eligible Veterans, from all eras of military conflict.

There is no single model for non-VA mental health care. The President's 2004 New Freedom Commission On Mental Health Report - Achieving the Promise: Transforming Mental Health Care in America was not focused on VA, but charged all healthcare systems to review their mental health care services: "Our country must make a commitment. Americans with mental illness deserve our understanding, and they deserve excellent care." Their conclusions were that "the System is fragmented and in disarray." To improve access to quality care and services, the Commission recommended fundamentally transforming how mental health care is delivered in America.

VHA's response to the New Freedom Commission was the development of a multifaceted Comprehensive Mental Health Strategic Plan, which took steps to accomplish the following: close gaps in availability of mental health care; transform the culture of care to one emphasizing psychosocial rehabilitation with a recovery orientation; facilitate integration of mental health services into primary care; and develop and implement evidence-based practices. VA's evidence based practices were based on the VA/DoD Clinical Practice Guidelines developed by interprofessional subject matter experts in psychotherapy, pharmacotherapy, and suicide prevention.

There was no organized non-VA response to the New Freedom Commission Report. However, progress has been made through the actions of many organizations. For example, the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration has come out in favor of transformation to the Psychosocial Rehabilitation and the Recovery model. Some health care programs support mental health benefits (e.g., Kaiser Permanente, United Health Care) but there is no overarching guiding model of care. Some professional organizations have or are developing clinical practice guidelines for mental health.

VA Mental Health developed a Uniform Mental Health Services Handbook that affirmed an interprofessional team care model and that emphasizes a high degree of collaboration in patient evaluation, treatment planning, and outcome evaluation. Ideally, the patient and family members are included as team members. VA mental health policy mandates the use of interprofessional teams in almost all settings, including primary care, rehabilitation, medical specialty clinics, and long term and end-of-life care. VA specialty mental health care settings include outpatient general mental health

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clinics, more specialized mental health outpatient clinics, mental health intensive care management, and residential rehabilitation treatment programs.

Council Discussion:

Council members were impressed with VA's advances in mental health care delivery, especially VA's comprehensive response to the recommendation of the President's New Freedom Commission on Mental Health. They complimented VA's integration of mental health care into overall health care delivery systems, noting that it was a model for the Nation.

The Council discussed a number of issues, such as including mental health diagnoses in an electronic health record; the role of family in treatment; staff burn out in mental health care; VA's suicide prevention efforts; and the special mental health needs of returning Veterans. The Council recommended that VA make every effort to share those successes with the wider health professions community.

Panel and Discussion: Integrating Education into Emerging Practice Models in Mental Health

Robert A. Zeiss, PhD, Director of Associated Health Education, OAA, VHA, moderated a panel on integrating education into emerging practice models in mental health. Panelists included Andrew S. Pomerantz, MD, National Mental Health Director for Integrated Care, VHA; Mary Schohn, PhD, Director, Mental Health Operations, VHA; Cynthia D. Belar, PhD, Education Directorate, American Psychological Association; Deborah J. Hales, MD, Director, Division of Education, American Psychiatric Association; Susan M. Adams, PhD, APRN, PMHNP, CNS-BC, FAANP, Director PMHNP Program, Vanderbilt University and Board Member, American Psychiatric Nurses Association.

Model of Mental Health Integration in VA PACTs

Drs. Andrew Pomerantz and Mary Schohn, VHA mental health leaders, discussed the integration of mental health services into VHA primary care delivery. VHA has established Patient Aligned Care Teams (PACTs) throughout VHA and has included mental health practitioners as integral members of the teams. Only those patients requiring a higher level of mental health care are referred to mental health specialty clinics. The PACTs embody a shared responsibility for co-located, collaborative care. A major goal is to identify mental health issues early, to institute evidence-based treatment, and to ensure that patients and family members receive appropriate follow-up and, where necessary, long-term care.

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Council Discussion:

The Council discussed the evidence base for team care, the integration of mental health with primary care, and metrics for measuring competency in team-based care. VHA and others are working toward the development of rigorous team-based metrics, but there is no general agreement as to which competencies are most important in the development of team skills. The Interprofessional Education Collaborative (IPEC) has proposed competencies but they still need to be tested in real world settings. Scheduling and clinical space were also noted to be significant barriers to incorporating trainees from multiple disciplines into team-based care delivery.

Perspective from Psychology

Dr. Cynthia Belar from the American Psychological Association presented the educational perspective from psychology. The discipline of psychology impacts multiple aspects of health and healthcare, and includes multiple roles within a variety of clinical, academic, and management settings such as assessment and triage; psychological interventions; consultation; health promotion and disease prevention; team building and evaluation; behavioral research; and education and training.

Professional education in psychology consists of 6-7 years of post-baccalaureate training, culminating in a doctoral degree. The profession is trying to incorporate clinical experiences earlier in the curriculum, so that from day one, students are involved in practical experiences and can better appreciate the interaction of research and practice. A requirement for award of the doctorate is a one year, full time clinical internship. Dr. Belar made special note of VHA's long-time commitment to pre- and post-doctoral training in psychology.

A major issue within the discipline in recent years has been the imbalance between the number of doctoral candidates and accredited internships sites. Trainees not "matching" with an accredited internship often arrange for the necessary clinical experience to receive their degree, but without an accredited internship such individuals are not eligible for VA staff appointments.

Perspective from Psychiatry

Dr. Deborah Hales from the American Psychiatric Association presented the educational perspective from psychiatry. The American Psychiatric Association is the oldest U.S. specialty society, formed in 1847. She presented a brief review of the evolution of psychiatry education. In medical school the model has been largely didactic in the pre-clinical years and the later inclusion of psychiatry as one of the core clinical clerkships. Longitudinal (as opposed to block) clerkships are on the horizon for

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psychiatry education in medical school. In residency education, Psychiatry has been a leader in the ACGME Milestone project, and has developed domains for each competency area at various levels of post-graduate training. This new system will be going live later this year.

Tele-psychiatry is becoming more prevalent. It is growing in California and in rural areas. Tele-psychiatry for resident supervision was controversial at first but now seems to be moving towards general acceptance.

Dr. Hales stated that the profession is encouraging review of the standard 4 year general psychiatric residency in order to allow for earlier specialization in important areas such as gero-psychiatry and addiction psychiatry. Agreement is also emerging that psychiatry should be more involved in interprofessional education and medical informatics.

Perspective from Psychiatric Nursing

Dr. Susan Adams from the American Psychiatric Nurses Association presented the educational perspective from psychiatric nursing. She described the various pathways to nursing practice. While the baccalaureate prepared nurse (BSN) is considered the entry degree to practice by many, there are many flourishing associate degree programs.

There are numerous avenues to becoming an advanced practice nurse (APN). These have long included master's degree programs post-BSN; however, the nursing profession is now coalescing around the doctorate of nursing practice (DNP) as the entry into practice for APNs as of 2015. Most DNP programs are post-masters level degree programs, with added elements of collaborative practice, informatics, and research.

With 182 current DNP programs and another 100 in the planning stages as well as numerous other new initiatives, there should be a steady pipeline of doctorally-prepared nurses in the near future. A significant challenge to the DNP programs is limited funding and clinical opportunities for DNP trainees. In addition to the DNP program, there are also more traditional PhD programs for nurses.

A major issue for psychiatric nursing education is finding the right place in these new nursing pathways for mental health specialization. In the past the primary pathway to mental health nursing practice was the clinical nurse specialist (CNS), which included specific certifying exams. Practitioners with these credentials are a "graying" population. Dr. Adams advised that these traditional and very experienced practitioners should be included in future planning along with newly minted DNPs with specializations in mental health.

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Dr. Bednash, Chief Executive Officer of the American Association of Colleges of Nursing, emphasized that the DNP is a new degree program and standard, not a new role for nursing. Most of the DNP degree programs emphasize collaborative practice.

Council Discussion:

With this background in mind, Dr. Zeiss asked the Council to consider potential directions for VA's mental health education enhancement initiatives over the next several years. What investments are needed and what kinds of innovations should VA ask local sites to develop? Council suggestions included:

- Capitalize on VA's many recent educational innovations by expanding the number of trainees exposed to VA's emerging care delivery system;
- Recognize VA's strides in interprofessional care delivery by including more trainees in collaborative care teams;
- Inclusion of more VA community training sites in undergraduate and graduate health professions education;
- Emphasize the importance of the family in designing mental health training programs;
- Include robust evaluation and scalability criteria in future RFPs, including specific attention to health outcomes;
- Develop innovative models of trainee supervision, and examine the relationship of team structure and supervision to clinical productivity;
- Engage trainees in problem solving and performance improvement programs in an interprofessional environment;
- Capitalize on VA's robust tele-health programs in mental health for trainee education;
- Provide substantive VA clinical experiences at earlier points in the continuum of educational programs in order to socialize trainees into interprofessional practice;
- Recognize VA's national impact on development of new roles for mental health providers;
- Encourage VA's collaborations with other federal, academic and professional association groups to advance interprofessional education and mental health care.

Wrap Up and Adjourn

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**Review of Discussions on Thursday January 10, 2012
Jordan J. Cohen, MD, Chair, NAAC**

Council members expressed strong support for exploration of VA joint ventures with the academic community and other public and private entities. Pursuit of identifiable opportunities and pilot projects should be a high priority in this time of a rapidly changing U.S. health care environment. Members were especially impressed with VA's advances in mental health care delivery, and encouraged inclusion of more trainees in VA's robust learning environment. The Council encouraged VHA to share its successes with the broader academic community and partner with others in the development of broad national efforts to implement interprofessional education and team-based care.

**Research Report
Joel Kupersmith, MD, Chief, Office of Research and Development (ORD), VHA**

VA Research Infrastructure

Dr. Joel Kupersmith, VHA's Chief Research and Development Officer, provided an update on the VA Research Infrastructure Program. He introduced and complimented Dr. Alex Chiu, the ORD staff member who led the recent examination of VA's research infrastructure. In response to a 2006 Congressional request, the Office of Research and Development established the VA Research Infrastructure Evaluation and Improvement Project to examine the physical infrastructure housing VA research programs. All stations with a minimum of \$500,000 in VA research funding and with on-site biomedical laboratory space were included. The study included 171 buildings at 74 VA campuses. The assessments were performed by contractors with architectural and engineering experience in the science and technology arena, accompanied and overseen by VA staff to ensure consistency in the assessment and reporting process.

The assessment teams examined the physical infrastructure of buildings housing biomedical and animal research, as well as the supporting systems that serve those buildings. Spaces were assessed for physical deficiencies, and capacity and suitability of the space to conduct research. Also assessed were: the architecture, plumbing, HVAC, electrical, and fire protection systems; security systems; life safety issues; functionality; and compliance with VA and NIH standards for laboratory design and construction. Costs were estimated for correction of deficiencies as well as building replacement. Identified deficiencies were assigned a priority for remediation from 1 to 5. The 2006-2010 costs to correct identified deficiencies totaled \$774 million. Thirty-nine per cent of deficiencies were identified as priority 1 and another 32% as priority 2. All assessments were completed between 2007-2010.

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VA has moved forcefully in the past few years to correct these deficiencies and in addition to construct new laboratories at a number of sites. Beginning in September 2012, ORD is collaborating with the VHA Office of Occupational Health and Safety to verify correction of life safety issues identified in the assessment. The results have greatly benefited the VA research enterprise.

Council Discussion:

Council members complimented VA on the thoroughness of this study. It was posited that if such a study were conducted at academic organizations, similar findings would most likely be found, and that VA was probably ahead of the curve in applying greater scrutiny to its research facilities. Council members raised the importance of adequate research facilities for recruitment at both VA and health professions schools, and emphasized the potential of greater partnership in this important area.

VA Office of the Inspector General's Audit of VA's Systems Interconnections with Research and University Affiliates

Dr. Kupersmith reviewed the VA Office of the Inspector General's (OIG) Audit of VA's Systems Interconnections with Research and University Affiliates published October 23, 2012. The intent of this audit was to determine the effectiveness of VA's management of network inter-connections and sensitive data exchanges with its research and university affiliates.

The VA OIG determined that there were numerous areas for improvement such as maintaining inventories of research data exchanges, locations of shared data, and security of shared data. The OIG provided a number of recommendations for improvement, such as implementation of a centralized data governance model; formalized agreements on data sharing and storage; and a focus on protection of sensitive data in accordance with VA information security requirements.

Dr. Kupersmith reported that the VA Office of Information and Technology and the VHA Office of Research and Development are working with the VA OIG to formalize action plans to address the recommendations without negatively impacting VA's research mission or its long-term relationships with the academic community. The Association of American Medical Colleges (AAMC) is working with VA to develop plans for data sharing between VA and university research partnerships that support the ultimate goal of collaboration and secure data sharing. A joint VA-AAMC taskforce is expected to suggest guidelines for policies and processes to enhance sharing data and participation in research projects.

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Council Discussion:

Council members discussed the conundrum of how to enhance collaboration and data security at the same time. There are enormous complexities of sharing data across institutions, yet pooling data in one or another system is problematic due to such issues as coding differences and documentation protocols. Council members brought up the regulatory and administrative burdens discussed at the information security discussions at the June 2012 NAAC meeting, and their impact on research collaboration between VA research and its academic partners. These issues are broader than this specific OIG report and speak to the need for stronger representation of the VA research and educational community in VHA and VA senior leader forums.

VA Liaison Committees

Representatives of two VA Liaison Committees provided summaries of the Committee's recent activities and accomplishments.

VA-American Association of Colleges of Nursing (AACN) Liaison Committee

Jane M. Kirschling, PhD, RN, FAAN, President of the American Association of Colleges of Nursing provided an update on the VA-AACN Liaison Committee. This Committee has met twice a year for the last several years to discuss current programs and future challenges and opportunities between VA and the Nation's colleges of nursing. Recent issues have included The VA Nursing Academy, programs for clinical nurse leaders, and transition to practice and residency programs for BSN graduates and nurse practitioner students.

Dr. Polly Bednash, CEO of the American Association of Colleges of Nursing complimented VA for its recognition of the value of a highly educated nursing workforce and its work with AACN to develop qualification standards for VA nurses and educational standards for AACN to enhance the preparation of nurses for practice. She praised VA for its policy recognizing BSN prepared nurses as leaders, and described VA's Patient Aligned Care Teams (PACTs) as a marvelous model allowing nurses to work at the "top of their expertise".

Dr. Kathleen Long, Dean of Nursing at the University of Florida commented that the Liaison Committee has given both partners opportunities to talk about the design of nursing education and preparation for practice. She stated her belief that the VA Nursing Academy (VANA) program had made significant progress in establishing the importance of utilizing both VA and School of Nursing faculty in new and innovative programs of nursing education.

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Council Discussion:

NAAC members discussed opportunities for nursing involvement in VA research, and the possibility of adding a VA research representative to the VA-AACN Liaison Committee.

VA-Association of American Medical Colleges (AAMC) Liaison Committee

John E. Prescott, MD, Chief Academic Officer, and Jack Krakower, PhD, Senior Director, Medical School Financial and Administrative Affairs, both from the Association of American Medical Colleges, provided an update on the VA-AAMC Liaison Committee.

Known since the 1960's as the AAMC VA-Council of Deans Liaison Committee, this committee has been re-configured in the last two years to include representatives from all areas of the VA-medical school partnership. A fall 2012 survey of deans about their concerns and opportunities revealed similar issues to those identified by the more comprehensive survey of stakeholders conducted for the Blue Ribbon Panel on VA Medical School Affiliations in 2007, identifying such recurring issues as contracting, IT, human resources and physician appointment processes as significant barriers, with only limited improvement over the ensuing 5 years.

Dr. Krakower reported that AAMC was developing a set of Frequently Asked Questions for school of medicine deans. This will be especially helpful as the turnover of school of medicine deans is high, and some new deans have had no prior experience with VA partnerships.

Council Discussion:

NAAC members were complimentary of the revitalization of the VA-AAMC Liaison Committee. The Council discussed the possibilities for formation of Liaison Committees with *other* disciplines with large numbers of VA trainees. VHA's Office of Academic Affiliations is currently considering forming such committees.

The NAAC discussed potential opportunities to create forums to discuss interprofessional education. Since individual professional groups rarely address trans-disciplinary issues it will be important to include all relevant professions in the development of exemplary interprofessional programs for VA and the larger health professions education community.

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Council Discussion: Future Meetings, Suggestions for NAAC Meeting Topics

Council members reviewed the timeframe for the next scheduled face-to-face meeting of the NAAC: November 14-15, 2013. They agreed that considering the time interval, one or more conference calls to provide update on progress would be desirable.

**Council Discussion: Formulation of Recommendations
Jordan J. Cohen, MD, Chair, NAAC**

Dr. Cohen led a discussion of potential recommendations for VA leadership. He emphasized that recommendations should be viewed in a framework of what's in the best interest of care for Veterans, and that all of U.S. healthcare is trying to accomplish more with fewer resources. The Council believes that the VA is in a unique position to capitalize on its advances in delivery of interprofessional team-based care and that it can lead the Nation in this area.

The National Academic Affiliations Council offers the following recommendations to VA leadership to assist in achieving the best care for Veterans through optimized clinical care delivery and health professions education.

1. The NAAC reaffirms the critical importance of the clinical learning environment in achieving educational goals for trainees. Therefore the NAAC recommends that VA incorporate relevant metrics of key clinical learning environment domains as fundamental considerations in the design of future educational initiatives.
2. The NAAC applauds the work of VA to deepen the impact of its mental health training programs in multiple disciplines, noting that "the Nation desperately needs innovation in mental health training models." The NAAC endorses VA's ongoing plans to continue expansion of the mental health trainee pipeline and recommends that consideration also be given to knowledge transfer from VA to non-VA venues and to the incorporation of community health elements into VA models of care.
3. The NAAC applauds VA's leadership role in promoting interprofessional education and practice, and encourages active collaboration with other Federal and State authorities and national professional associations and groups with similar goals.
4. The NAAC recommends that the impact of information security on joint educational and research initiatives between VA and the academic community be taken into consideration when optimizing existing and designing new security measures. This might best be accomplished by adding senior leadership from the Office of Academic Affiliations to the HPSP-12 Committee, given the importance of maintaining and enhancing the academic mission to VHA clinical

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operations. Likewise, the NAAC also recommends that consideration be given to adding senior leadership from the Office of Research to the HPSP-12 Committee.

5. The NAAC commends VA for its enhanced communication with the academic nursing and medicine communities via VA-American Association of Colleges of Nursing (AACN) and VA-Association of American Medical Colleges (AAMC) Liaison Committees and recommends that additional communications platforms be developed for other health professions.
6. The NAAC emphasizes the need for a strong voice and content expert for the “academic” mission of VA (education and research) at the highest levels of decision making in VHA. This might best be accomplished by adding senior educational and research leadership to the VHA National Leadership Council.

Public Comment:

No members of the public provided comments.